INFORMED CONSENT

Physical therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury, and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided, you may be asked to disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure, and/or request another therapist.

There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing degrees of difficulty that could cause an increase in your current level of pain or discomfort or an aggravation to you existing injury. You will be able to stop treatment if you feel any discomfort or pain. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. I have read and received a copy of the consent form and authorized release of medical information to appropriate third parties.

Patient's Signature_____ **Date**_____

Signature of Parent _____ **Date**_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account or any professional services rendered. I have read all the information and have completed the above answers. I certify all information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

Parent (if minor): _____ Date:_____